Croydon
Safeguarding Children Board

The Overview Report

into a

Serious Case Review of the Circumstances Concerning

Josh

Independent Author
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CONFIDENTIAL
UNLESS PUBLICATION AGREED BY LSCB

The Family Structure at the start of the review period

Claire	04/12/1972	F	Mother
Josh	**16/03/2010**	**M**	**Subject**
	11/04/1955	F	Maternal Grandmother
	27/05/1943	M	Partner of Maternal Grandmother
	10/08/1985	M	Father
	N/K	F	Aunt
	N/K	F	Aunt
	N/K	M	Maternal Grandfather

1. Introduction

1.1 Who was Josh?

1.1.1 Josh was a bright happy 3 year old boy and he was the only child in his family home which he shared with his Mother Claire, his Maternal Grandmother and her partner. The family home is a semi-detached house in a suburban area which is spacious, clean and tidy. It is a good environment in which to bring up a child.

1.1.2 His father lives in Egypt and Josh rarely met him. It is not believed that his father contributed to his upbringing and it was noted by the childminder that Josh seldom spoke about his Father, other than mentioning him a handful of times after he had returned from a visit to Egypt.

1.1.3 Josh was generally a healthy child who was developing well. His immunisations were up to date and he attended all health related appointments. He appeared well cared for and when seen by professionals his interaction with his Mother and Grandmother seemed appropriate.

1.1.4 His childminder also noted that Josh appeared to be *'well cared for, happy, sociable and chatty. He was in line with appropriate development bands in accordance with his age.'* All the available evidence suggests that he was brought up and nurtured in a loving way by his Mother and Grandmother and extended family, and there is no evidence of neglect or maltreatment.

1.1.5 This Serious Case Review has Josh at the centre and this moving passage, taken from the written contribution to this Review by his Grandmother, gives a perfect picture of Josh.

> *'Our Grandson, I will never hear him say nana, hear his laughter and see that big mischievous grin. We used to dance to the radio or the TV whenever he heard music he would start dancing, he loved playing in the park he kissed trees and rolled down the hills he loved the garden going on his slide he wasn't so keen on his swing, playing with his Fireman Sam ball he loved picking the flowers only the heads after he smelt them, he loved playing in his paddling pool. He loved his bubbles and soaking the floor, he loved bedtime stories and we always got a big kiss at bedtime. He loved to sit and watch his favourite TV programmes with you.'*

1.2 Brief Summary of Circumstances Leading to the Review

1.2.1 The case in question was triggered by the death of Josh. On 22nd March 2013, Josh was taken by his Mother to a railway station

near their home whereupon Josh was carried onto the tracks and held in the path of an oncoming train by his Mother, killing them both.

1.2.2 During the preceding months, Claire had a history of severe anxiety disorder with some panic attacks and some limited depressive symptoms. She had been receiving treatment from her GP as well as various other health professionals and agencies.

2. Process of the Review

2.0.1 On the 25th March 2013, the LSCB Serious Case Review Subgroup met to decide whether a Serious Case Review was required following the deaths of Josh and his Mother. The British Transport Police is currently investigating the double fatality of both Claire and Josh. Consequently, those present at the meeting agreed unanimously that a Serious Case Review was required under Section 4 of the Statutory Guidance *Working Together to Safeguard Children* (2013).

2.1 The Statutory Basis for Conducting a Serious Case Review

2.1.1 The role and function of a Local Safeguarding Children Board is set out in law by *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*. Regulation 5 requires the LSCB to undertake a review in accordance with guidance set out in Section 4 of Working Together to Safeguard Children (2013). The mandatory criteria for carrying out a Serious Case Review include where –

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) the child has died; or

(ii) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

2.1.2 The product of the Review, known as the Overview Report, is sent to the Secretary of State for Children, and scrutinised by the Department for Education. All reviews of cases meeting the SCR criteria must result in a report which is published.

2.1.3 Revised *Statutory Guidance on Learning and Improvement* published by the Department for Education as a consultation draft in June 2012, prescribes that SCR reports should be written with publication in mind and should not contain personal information relating to surviving children, family members or others. This includes detailed chronologies, family histories, genograms, or

information known to organisations about the child and family members. Where possible, this Overview Report has been prepared within the spirit suggested and, whilst ensuring any lessons are learnt, every effort has been made to minimise distress for the surviving family members. Personal information about life within this family has been kept to the minimum required to provide a thorough and meaningful report into this review, although my analysis of practice benefited from a great deal of more detailed information contained within the agency reports, which are listed below.

2.1.4 Serious Case Reviews should be conducted in a way in which

- Recognises the complex circumstances in which professionals work together to safeguard children;

- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;

- Is transparent about the way data is collected and analysed; and

- Makes use of relevant research and case evidence to inform the findings

2.1.5 LSCBs may use any learning model which is consistent with these principles, including the systems methodology. Having decided to undertake a serious case review to look at how well agencies were working together to support Josh and his family it was decided to implement the systems methodology provided by the Significant Incident Learning Process (SILP).

2.1.6 The key principle of SILP is the engagement of frontline staff and first line managers in conjunction with members of LSCB Serious Case Review Panels or Subcommittees, Designated and Specialist Safeguarding staff, etc. The involvement of frontline staff and first line managers gives a much greater degree of ownership and therefore a much greater commitment to learning and dissemination.

2.1.7 The SILP is a collaborative and analytical process. The main focus is to extract learning from the detailed study of a set of circumstances. From a practitioner's point of view it takes account of:

- their view of what was going on in and around this case
- how they understood your role or the part you were playing

- their thinking and your context at the time
- their perspective on what aspects of the whole system influenced them as a worker
- the tools they were using

2.1.8 By taking account of these things, the process focuses on understanding why someone acted in a certain way. It highlights what factors in the system contributed to their actions making sense to them at the time. This process is NOT about blame or any potential disciplinary action, but about an open and transparent learning from practice, in order to improve inter-agency working. Importantly, it also highlights what is working well and patterns of good practice.

2.2 Independence

2.2.1 Working Together to Safeguard Children (2013) also mandates that reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed. The LSCB should appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. To ensure transparency, and to enhance public and family confidence in the process, the LSCB Chair appointed two independent people to lead this Serious Case Review.

2.2.2 In his document *Protection of Children in England: A Progress Report* Lord Laming (2009) expressed the view that in carrying out a Serious Case Review, it is important that the chairing and writing arrangements offer adequate scrutiny and challenge to all the agencies in a local area. For this reason, the chair of an SCR panel must be independent of all of those local agencies that were, or potentially could have been, involved in the case.

Ms Donna Ohdedar – SILP Lead Reviewer and Panel Chair

2.2.3 Ms Ohdedar was appointed to chair the SILP and oversee and manage the review process in this case. She was the lead person for ensuring that a robust and transparent review was carried out within each relevant agency, and for ensuring that the business management plan and timescales were strictly adhered to.

2.2.4 She has had no involvement directly or indirectly with the child or any members of the family concerned or the services delivered by any of the agencies.

2.2.5 Ms Ohdedar is a solicitor with 18 years local government experience, latterly as Head of Law in a metropolitan authority. With a grounding in child protection law and advocacy, she also practised in a variety of other areas of regulatory law and governance and held

the statutory role of Monitoring Officer within her authority. She was involved in Area Child Protection Committee, was instrumental in the formation of a children's trust in a pathfinder authority and was a member of the Local Safeguarding Children Board.

2.2.6 Upon leaving local government in 2010, Ms Ohdedar commenced a second career as a safeguarding adviser, investigator and trainer. Alongside her involvement in the conduct of serious case reviews she takes a keen interest in alternative forms of review and delivers the Significant Incident Learning Process (SILP).

2.2.7 She is a member of the British Association of Adoption and Fostering Legal Group Advisory Committee and is passionate about improving outcomes for children in the child protection system.

Dr John Fox MSc, PhD – Independent Overview Report Author

2.2.8 Dr Fox was responsible for drawing together all elements of the individual agency reviews, and for obtaining as much relevant information as possible from family members and significant others who might provide useful learning. He was responsible for analysing the professional practice of professionals and organisations and making recommendations to the LSCB for further action to better safeguard children.

2.2.9 He has had no involvement directly or indirectly with the child or any members of the families concerned or the services delivered by any of the agencies. He has never worked for, or been affiliated with, any agency in Croydon.

2.2.10 Dr Fox is a Senior Lecturer at the University of Portsmouth and previously was a police officer for 31 years including 8 years as a Detective Superintendent and Head of Child Abuse Investigation in the Hampshire Police. He sat as a member of 4 LSCBs and was Vice Chair of Hampshire ACPC.

2.2.11 He represented the Association of Chief Police Officers on various Government working parties and committees, concerning child abuse and related issues, including the drafting of the *Working Together to Safeguard Children* documents (1999, 2006, and 2013) and *Achieving Best Evidence in Criminal Proceedings*, and had the ACPO lead portfolio role for Childhood Death and Forensic Pathology. He was appointed as the Police Service representative to Baroness Helena Kennedy's Intercollegiate Working Group on childhood death and was Lord Laming's police advisor and assessor, on the Victoria Climbie Inquiry.

2.2.12 He has previously chaired Serious Case Review Panels, and is regularly commissioned as Overview Report Author by LSCBs. During

the period when Ofsted were evaluating SCRs, all his reports were graded as outstanding or good. In 2009, he conducted secondary evaluations, and provided reports as Independent Author concerning 4 Serious Case Reviews that had earlier been considered inadequate by Ofsted and the Welsh Assembly Government.

2.3 SILP Agency Reports

2.3.1 Although Individual Management Reviews are no longer required under Government guidance, the SILP process includes individual agency reports.

2.3.2 The SILP process also requires that those conducting agency reviews of individual services should not have been directly concerned with the child or family, or given professional advice on the case, or be the immediate line manager of the practitioner(s) involved.

2.3.3 The people preparing the individual agency reports for this Review were all approved by the professionals engaged in the SILP process and the Independent Author, as being senior personnel within each agency who were completely independent of any involvement or line management responsibilities concerning the case. On 9th May 2013, the Individual Agency Report Authors were briefed as to their responsibilities by the Independent Lead Reviewers. They were particularly asked to focus on Josh, and what life was actually like in his household.

2.3.4 The Lead Reviewers decided that the following agencies and organisations would be asked to contribute to the learning of this Review.

Individual agency report provided by:
Croydon CCG (GP)
Bromley Healthcare Acute
Croydon Children's Social Care
British Transport Police (Also covering services provided by the Metropolitan Police and South Yorkshire Police)
Croydon Health Services NHS Trust
Rotherham, Doncaster & South Humber (RDaSH) NHS Foundation Trust

South London Health Care Trust
South London and Maudsley NHS Foundation Trust (covering services provided by Community Mental Health Teams)

Factual Report provided by:
London Ambulance Service
Childcare
Private Psychiatry LLP
Private CBT Therapy

2.3.5 The LSCB provided each agency report author with a SILP template to assist in the writing of their reports, and this was successful in achieving standardisation and consistency, as well as ensuring that the reports focused on the areas required by the Terms of Reference. Each individual agency report author was invited to present their report to the SILP meeting where any clarification was provided, or additional work requested. In addition to this, where necessary, I had direct contact with members of the Agency Review Team in order to best inform my analysis in this Overview Report.

2.3.6 It was noted by Ofsted (2010) that the duties of the Overview Report Author include *'challenging the quality and content of individual agency reviews and ensuring that the overview report compensates for any identified deficiencies.'* Collectively, the quality of the Agency Reports was sufficient for me to understand the case and provide an analysis of the significant issues.

2.3.7 In addition to the Agency Reports mentioned above, the SILP review was also informed by a report prepared by an investigation team appointed by the South London and Maudsley NHS Foundation Trust (SLaM) who carried out a separate single agency inquiry into the services provided by that organisation. The report, which was received in late November 2013, mirrors much of the material provided by the SLaM SILP Agency Report but in certain areas provides a little more detail and context and it helped with the analysis.

2.4 The Practitioner Events

2.4.1 An initial scoping meeting was held at the beginning of the review process and this was followed by a briefing day for those professionals selected to write agency reports.

2.4.2 A Learning Event with over 30 attendees comprising agency authors, Designated and Specialist staff, LSCB Serious Case Review Subgroup, front line practitioners and their first line managers took place on 25th June 2013, and on 18th July 2013, a Recall Half-Day was held for all those who attended the Learning Day to consider and debate the first draft of this Overview Report.

2.4.3 Agency attendance at these events was generally very good. It is a matter of regret that although invitations were sent to three of their senior staff, no representative from Children's Social Care attended the main SILP Learning Event. This resulted in a number of gaps in the information available to the Reviewers. The independent practitioner commissioned by Social Care to write their agency report was present, but she was in a difficult position in that she was not there as a representative of the Local Authority and therefore, was unable to answer some questions about the services provided. Children's Social Care were appropriately represented at the subsequent Recall Day.

2.4.4 The Independent Reviewer chairing these meetings was assisted by the LSCB Development Manager as well as an administrative support officer at most meetings.

2.4.5 Agency attendees included:

Agency	**Name**	**Independence Status & Experience**
Independent Lead Reviewer, (Chair)	Donna Ohdedar	Experienced in audit and Serious Case Reviews. No direct case involvement.
CSCB Development Manager, Croydon Social Care	Representative	Experienced in audit and child death case reviews. No direct case involvement.
Children's Social Care	Representative	Experienced in audit and Serious Case Reviews. No direct case involvement.
Croydon Health Services	Representative	Experienced in audit and Serious Case

		Reviews. No direct case involvement.
Croydon Clinical Commissioning Group	Representative x 2	Experienced in audit and Serious Case Reviews. No direct case involvement.
British Transport Police	Representative	Experienced in audit and Serious Case Reviews. No direct case involvement.
SLAM	Representative	Experienced in audit and Serious Case Reviews. No direct case involvement.

2.5 Scope and Terms of Reference

2.5.1 Time period: **1 June 2012** (date of first presentation to GP with anxiety related issues) to **22 March 2013** (date of incident). Agencies were also asked to provide relevant information relating to Claire's pregnancy and antenatal period and to the 3 head injuries sustained by Josh even where these fall outside the scoping period.

2.5.2 The Terms of Reference were discussed and agreed at the first SCR Panel meeting on 26th April 2013. They were then ratified by the Independent Chair of the LSCB and thereafter became the instructions to the two independent people about the scope required for the Review.

2.5.3 The Terms of Reference specified the following 3 *'Key Issues in this case'* together with a requirement that these questions need to be covered by Agency authors and covered within the Overview Report.

1. What was known and identified by professionals about Claire's parenting capacities and possible risks to Josh?

2. Did assessment and/or care plans take account of the whole family and potential risks to Josh and how was information shared with relevant agencies?

3. What was the outcome of the referral to Children's Social Care and the rationale behind the decision making process?

2.5.4 The full Scope/Terms of Reference can be found at Appendix A.

2.6 The Voice of the Family and Significant Others

2.6.1 The Statutory Guidance requires that families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. A commitment to providing the fullest opportunity for individuals with a close connection to the family to be invited to participate in the review was agreed at the first scoping meeting.

2.6.2 In order to gain as much learning as possible from Josh's family, the Lead Reviewers reached out to them in the following ways:

- A letter explaining the process went out on 2nd May 2013 to Josh's Maternal Grandmother, as well as Claire's two sisters and her Father. The letter was jargon-free and as non-businesslike in tone as possible. The British Transport Police also wrote to the Josh's Father in Egypt offering him the opportunity to participate in the review using the translation service they had used to correspond with him on other issues.

- A Lead Reviewer met with Josh's Grandmother on 9 May 2013. On this occasion, she expressed a wish to participate in the review. She also expressed some of her views about services.

- On 13th May 2013, a second letter was sent to the four people named above offering a second meeting with the Lead Reviewers on 24th June. This letter outlined the 3 areas for consideration, i.e. What did services do well? What did they not do so well? How can services be improved?

- On 20th June 2013 Josh's Maternal Grandmother agreed to meet the Lead Reviewers, but indicated that her two daughters would not want to meet as *'they haven't got anything to say'* and 'it would be more hurtful for them to be there'.

- In order to engage Josh's father in the review the British Transport Police (BTP) kindly offered their assistance. Their officers, together with the Honorary Consul from the British Consulate, had met with him in Egypt as part of their investigation. However, since that point he has not responded to messages or phone calls made by the Honorary Consul attempting to deliver the letter inviting him to contribute to the Serious Case Review. A BTP detective also tried to contact Josh's father via his mobile phone but this again has proved to be unsuccessful.

- Also on 20th June 2013 a Lead Reviewer contacted Claire's father by telephone, and he stated *'the services ain't no good. It's the doctors and the psychiatrists who gave her the stronger and stronger tablets so she took her own life.'* He felt that if they had helped her more she would be alive now and he would not have lost his grandson. He added *'they don't know what they're doing. I hope to God it don't happen again.'*

- Both independent Lead Reviewers met with Josh's Maternal Grandmother and her partner at their home on Monday 24th June 2013, and they contributed very helpfully to the learning in this review. The views of both Josh's Grandmother and her Partner were shared by the Lead Reviewers with all professionals attending the Learning Event.

2.6.3 In addition to the meeting on 24th June 2013 between the Lead Reviewers and Josh's Grandmother, she was invited to attend for the latter part of the Learning Event on 25th June 2013. Josh's Grandmother wanted to attend with a friend to be present to support her but the Safeguarding Children Board required that she must be accompanied by an 'objective supporter' rather than a friend or family member. Josh's Grandmother was very upset by this condition and declined to attend. It is noted that attendees at the Learning Event acknowledged how hard it would be for family members to attend such a meeting with so many professionals, and the difficulties for them to engage dispassionately in discussion about events which affected them so deeply and personally.

2.6.4 Finally, a comprehensive written report prepared by Josh's Grandmother was received on 16th August 2013. Although it would have been very helpful to have had this report earlier in the SCR process in order to better allow agencies and practitioners the opportunity to respond to the points made, the report was considered by the independent reviewers and it helped to inform the analysis in the Overview Report, and some Agency Reports were revised to take account of it. For completeness, and to ensure the voice of the family is heard to the fullest extent, the entire (anonymised) report is included as an appendix.

2.7 Individual Needs

2.7.1 The guidance in *Working Together to Safeguard Children* requires consideration to be given to individual needs - racial, cultural, linguistic and religious identity – of the child who is the subject of a Serious Case Review.

2.7.2 Josh's father is of Middle Eastern heritage and lives in Egypt. Josh was named in accordance with Islamic tradition and Claire and Josh travelled to Egypt for a 3 week period in June 2012, but as far

as is known Josh was brought up in a middle class white British environment. There was no evidence in the material that any issues of race, religion, language or culture affected events in this case or should have been significant in influencing the practice or approach taken to the delivery of services.

2.7.3 Josh lived in a quiet neighbourhood in South Croydon. The family home is a very clean, well maintained semi-detached house with a large rear garden which backs onto woodland.

2.7.4 There is no evidence of poverty within the family and there is no evidence in health records to suggest that this family experienced social or any other form of exclusion. It is reasonable to conclude that Josh had no individual special needs.

2.8 Accountability for the Overview Report

2.8.1 I attended the scoping meeting, the authors' briefing, the Learning Event and the Recall Day i.e. all meetings involved in the process.

2.8.2 Whereas I am accountable for the content and analysis within this Overview Report, the participants in the Learning Event and Recall Day have contributed to the process of the preparation and have offered helpful comments and suggestions during the drafting process.

3. The Facts - Summary of agency involvement

Source

This section is designed to summarise the key relevant information that was known to the agencies and professionals involved about the parents, and the circumstances of the child. Since the Review is primarily concerned with Josh, only events which may have affected him, or the capacity for adults to look after him, have been included in this section.

3.1 Significant events in Josh's early life

3.1.1 Josh was born on 16th March 2010. The Community midwives attended Josh and his mother at home and there were no concerns shared with the Health Visiting service at handover (when community midwives discharge to the Health Visitor). — CHS RPT.

3.1.2 On 13th May 2011, Josh was seen at Princess Royal Hospital Emergency Department with Claire. The reason for the attendance was a head injury. The mechanism of the injury was given as a fall, hitting the back of head on a TV table. A small red bruise was noted, consistent with the history of the injury. — CHS RPT. SLHT RPT.

3.1.3 Records at Croydon University Hospital show that Josh was brought to the Emergency Department by ambulance with his Mother Claire on 23rd July 2011 following a fall at home from a plastic chair and hitting his head on a marble fireplace. He sustained a 1cm bruise to the left side of his head. — CHS RPT.

3.1.4 Josh again attended the Princess Royal Hospital on 9th October 2011. He was accompanied by his Mother who reported that whilst playing he hid behind a sofa and hit his head on the wall causing a bruise to the scalp. — SLHT RPT. CHS RPT.

3.1.5 Claire and Josh travelled to Egypt for a 3 week period in June 2012. Claire had lost a lot of weight during this period having already exhibited signs of anxiety from May 2012. These symptoms consisted of sweating and shaky hands.

3.2 The Relevant Period of the Review

3.2.1 In July 2012, Claire self referred to the local IAPT Psychological Therapies and Well Being Service. She stated that she has not received previous care from mental health services, psychological therapies or counselling services and had no previous episodes of self harm or suicide attempts. — SLaM RPT.

3.2.2 On 20th July 2012, Claire attended the Emergency Department by ambulance complaining of palpitations. It was recorded that Claire commenced Sertraline medication the — LAS RPT. CHS RPT.

previous day as prescribed by her GP. She was seen by a casualty Senior House Officer who recorded that Claire disclosed she had suffered severe anxiety for the last 2 months.

3.2.3 On 18 September 2012 Claire, attended Private Psychiatry outpatient clinic at Fitzroy Square Hospital in London, on referral from her GP. She was referred with a history of severe generalised anxiety with panic attacks, having had difficulty tolerating two antidepressants. In total Claire attended for five sessions following the initial assessment appointment. The last session she attended was on 2 November 2012. In her therapy sessions she constantly talked about how important her son was to her indicating that he was the only thing that she was really motivated and committed to. PP RPT.

3.2.4 Her family contacted the Private Psychiatry office between 23rd and 26th November indicating that she would not be attending any further appointments. PP RPT.

3.2.5 On 13th November 2012, Claire and her Mother self presented in crisis to the SLaM Community Health Team. She recounted the events of the previous 48 hours. On the evening of 11th November 2012, she took Citalopram 20mg as prescribed and went to bed. She reported getting up in the middle of the night, totally unaware of what she was doing, and held a knife to her throat, fighting off her Mother's attempts to take the knife from her. SLaM RPT.

3.2.6 On 16th November 2012, a telephone and email referral from CT1 psychiatrist was made to Children's Social Care suggesting that Josh may be living within an emotionally difficult environment. SLaM RPT.

3.2.7 On 19 November 2012, at 08.39am the referral from CT1 psychiatrist, in the form of an email, was forwarded from a Customer Service Advisor, Initial Contact Centre in the local authority to the Children's Assessment Team. A decision was made to request further information and to have the referral resubmitted with extra information. CSC RPT. SLaM RPT.

3.2.8 A Croydon Children's Social Care referral form was received by Children's Social Care from CT1 psychiatrist, via email on 27/11/2012 at 11.30am. No action was taken as a result of this referral. CSC RPT.

3.2.9 On 4th December 2012, Claire called the local community mental health team and spoke with CT1 psychiatrist. Claire said she had been having sensations of panic all day and felt she was not looking after her Josh properly. SLaM RPT.

3.2.10 On 7th December 2012, having been referred by her GP, Claire was seen by a Psychiatric Liaison Service 1 in Croydon University Hospital A&E. She was referred for mental state review due to her high level of anxiety. During this consultation with the psychiatric liaison practitioner, she denied any suicidal intent or plans and cited her son as a protective factor. She expressed a strong commitment to parenting her son. It was agreed that Claire would see her GP on Monday, and her stepfather and Mother to hold medication to ensure it is only used as required.

CSC RPT.

CHS RPT

SLaM RPT.

3.2.11 On 14th December 2012, Claire was staying with a friend in Rotherham. The friend, unable to rouse Claire, called the emergency services and both the ambulance service and officers from the local home office force attended the premises. Two officers found that Claire was unconscious. The paramedics arrived within a short time of the officer's arrival and carried out a medical assessment. Following the examination, Claire was taken by ambulance to Rotherham District General Hospital Claire was admitted to Critical Care via A&E following an overdose of medication.

Rotherham RPT.

Police RPT.

3.2.12 On 15th December 2012, she was assessed by a social worker in the Psychiatric Liaison Service 2 who noted that Claire presented with acute but severe anxiety. The outcome of the assessment was an urgent referral to SLaM proposing an Intensive Home Service in her home locality of Croydon.

RDaSH RPT.

3.2.13 Claire was subsequently discharged to the care of her Mother on the 16th December 2012 and advice given regarding mental health law and how a formal mental health assessment may be sought. Following Claire's discharge from the hospital in Rotherham, the family expressed concerns about the lack of contact from the local mental health team and requested intensive psychological therapy at home.

SLaM RPT.

GP RPT.

3.2.14 On 17th December 2012, Claire's GP made telephone contact with the duty worker at the SLaM Community Health Team requesting assessment for suitability for home treatment following the overdose in Rotherham.

SLaM RPT.

3.2.15 On 31st December 2012, Claire and her Mother attended an out-patients appointment with SLaM Community Health Team CT1 psychiatrist. Claire was not thinking of harming herself but stated she wanted help. Claire also informed CT1 psychiatrist that she did not feel she was being a mother to her son as her own Mother was caring for him. The risk of harm to herself was documented as low.

SLaM RPT.

3.2.16 On 17th January 2013, Claire was taken by Ambulance to Croydon University Hospital with her Mother. It is reported that Claire's sister called an ambulance following a comment Claire made about not wanting to be around anymore and feeling suicidal. A triage nurse recorded that Claire suffered with extreme anxiety. Claire was seen and assessed by a Psychiatric Liaison Nurse. Claire stated that her main concern was her anxiety and the need for help and she denied any suicidal intent or plan. Claire was discharged home and referred to Community Mental Health Team.

CHS RPT.
SLaM RPT.

LAS RPT.
Police RPT.

3.2.17 On 18th January 2013, a referral was apparently made by CT1 psychiatrist to Children's Social Care although that agency has no record of receiving such a referral.

SLAM RPT.

3.2.18 Two outpatient appointments were offered to Claire as a result of the events on 17th January but she did not attend either appointment.

3.2.19 Between January 2013 and March 2013, Claire's Mother arranged for private Cognitive Behaviour Therapy (CBT) sessions to be conducted with Claire at the family home. The practitioner would see the child come and interact with the mother after the session had finished. Eleven CBT sessions were conducted and at the initial session on 12th January 2013, Claire reported feelings of anxiety and loss of self esteem. The practitioner observed nice, positive and a loving interaction between the mother and the child. The therapist recorded that Claire progressed well in her treatments, reducing her level of anxiety to such an extent that she was able to interact more with her son in terms of reading stories, baking cakes, bathing him. Throughout the course of the therapy no safeguarding issues were raised in respect of Josh, either by the family or as a result of observation by the therapist. The last session was held on 9th March 2013 and Claire said she did not have any active suicidal ideation or risk of harm to herself. She expressed some optimism for the future and that she wanted to get better for the sake of Josh.

CBT Report

3.2.20 On Friday 22nd March 2013, Claire, holding Josh, stepped down onto a railway track and they were both killed by an oncoming train.

4. A Day in the life of Josh and his family

4.01 Until the day of his untimely death, Josh was described as a happy, bright child. For much of his life, his mother Claire worked full time and the daily routine was appeared to be shared by his Maternal Grandmother, her partner and Claire. It was reported that the maternal grandmother had a significant role in the care of this family as a whole.

4.02 Because Claire worked full time Josh attended a registered childminder each weekday until January 2013. On the 23rd January, Claire decided to spend more time with Josh, and his sessions with the childminder were reduced to 2 or 3 days a week. This coincided with Claire losing her job.

4.03 The childminder noted that during this period she would often see Claire and Josh out and about e.g. going to the park and shops and they seemed happy together.

4.04 Josh was undoubtedly loved and nurtured within his family although as Claire's anxiety worsened it was reported by the GP that she stopped washing him and dressing him in the mornings, with this role being taken on by his Grandmother. In the latter part of his life therefore, Josh's Grandmother was the main carer of this family and this was considered by the GP to be a protective factor.

4.05 In her written contribution to this SCR, Josh's Grandmother confirmed that when Claire was at her worst, and couldn't cope, she and her partner took over Josh's care. She also pointed out however that Josh's life did not change when Claire wasn't well and that *'he saw his mum on a daily basis'* and always gave her a kiss in the morning and at night.

5. Analysis of Key Episodes and the Lessons Learnt

5.01 The main period covered by the SILP Serious Case Review starts in June 2012. However, Josh was taken to hospital with minor head injuries on three occasions before that date and this pattern of events was included within the terms of reference and the relevant Agency Reviewers have carefully considered the circumstances of each presentation.

5.02 It should be noted that these accidents occurred when Josh was between 14 and 20 months of age when children are becoming more mobile. There was an explanation given each time that was consistent with the injury and there was no suggestion in any hospital records that the head injuries may have occurred as a result of maltreatment.

5.03 Josh was provided with a universal health visiting service during the early months of his life and the health visiting team did not receive any information from any other agency that there were any safeguarding concerns for this child. The health visitors themselves expressed no concerns about Josh. In addition, Josh had attended the GP's surgery on 17 occasions, accompanied by Claire, for general consultations appropriate to the time of year and his age. There were no concerns about his health among the doctors at the surgery.

5.04 Whereas it was important that this SILP Review considered all aspects of Josh's care, there was no evidence found of any maltreatment related injuries and therefore no reason why any professional should have raised concerns about him as a result of these earlier hospital admissions.

5.05 The remainder of this analysis section is not arranged chronologically but covers four 'key episodes' and will examine whether there was any reasonable possibility that an agency or individual professional could or should have been able to predict the events which occurred on 22nd March 2013. The analysis will consider the case specific themes prescribed by the Terms of Reference

- What was known and identified by professionals about Claire's parenting capacities and possible risks to Josh?

- Did assessment and/or care plans take account of the whole family and potential risks to Josh and how was information shared with relevant agencies?

5.1 Referrals to Children's Social Care

5.1.1 Until a few months before Josh's death, Children's Social Care had no involvement with, or referrals about him or his family.

5.1.2 On 13th November 2012, Claire and her Mother sought help from the Community Health Team. This team is part of the range of services provided under the umbrella of South London and Maudsley NHS Trust (SLaM) and according to the website of this team, it '*provides advice on the best treatment and care options available to people who have moderate to severe mental illness, such as anxiety, depression or personality disorder'.* Claire explained to the duty mental health professional that on the evening of 11th November 2012, she took Citalopram 20mg as prescribed and went to bed. She reported getting up in the middle of the night, totally unaware of what she was doing, and held a knife to her throat, fighting off her Mother's attempts to take the knife from her. She believed that the behaviour was caused by anxiety, it was impulsive, she had not

planned it, had no intention to end her life and the events had scared her very much.

5.1.3 The assessment found the risks to Claire to be low and her family was identified as a protective factor. The duty worker advised Claire to visit some online support sites and she was discharged back to her GP. There is no evidence that the safety of Josh was particularly considered or discussed during the interview with the SLaM Community Health Team, although it is recorded that *'a child risk assessment was also completed, following this contact.'* The duty nurse documented in the referral letter to the GP that she had discussed her conclusions at the team meeting. This was explored by the SLaM Agency Reviewer with the nurse at interview who acknowledged that it in fact it was unlikely she had actually discussed the case at the team meeting, as the appointment was on Tuesday, the letter was uploaded on Thursday and the team meeting would not have taken place until the following Monday.

5.1.4 At the SILP Learning Event, the structure of the SLaM Community Health Team case meetings was discussed and it was noted that the gap in discussing Claire's case was due to *'no medic being present at the team meetings.'* A full exploration of this issue has taken place and it was explained that there was first of all an informal discussion within the team prior to the letter being written to the GP and that was followed a few days later by a formal team meeting with a medic present. Although as a result of the SLAM investigation there is a discrepancy that has arisen to suggest that recollection of events is now doubtful.

5.1.5 Claire was asked to return to the SLaM Community Health Team for a full appointment to review her medication. This visit took place at 14.30 hrs on Friday 16th November 2012 and Claire, accompanied by her Mother, met CT1 psychiatrist the team junior doctor. She was given a preliminary diagnosis of 'generalised anxiety disorder secondary to life events.'

5.1.6 CT1 psychiatrist also told Claire that he was going to make a referral to Child and Family Social Services, although it is not clear if he explained to them that he was concerned primarily about Josh.

5.1.7 At the SILP Learning event, CT1 psychiatrist explained that when he saw Claire he wondered if Josh had seen her holding a knife to her throat and he also asked about the atmosphere in the house. It is clear therefore that CT1 psychiatrist was considering Josh's welfare and he explained at the Learning Event the difficulties in making a judgement in just a 30 minute clinical appointment, and that as he had not seen Claire in her home he felt that more information was needed and that Children's Social Care should '*step in here*.'

5.1.8 Although CT1 psychiatrist had an awareness of safeguarding children, it appears that he lacked complete awareness of the safeguarding referral process and procedures, and it was noted in the CSC IMR Report that *'there was some confusion whether the referrer initially thought they were making a CAF referral or safeguarding referral.'* The view of the SLaM internal investigation team (see paragraph 2.3.7 above) is that the wrong format (i.e. email) was used for this referral, which was unhelpful, but this should not have affected the action taken by Children's Social Care because the analysis in the SLaM Agency Report concludes that the purpose of the referral and the form used are consistent with a clear understanding that the referral was a child protection referral, which was simply misnamed by the doctor.

5.1.9 However, there is no implied criticism of CT1 psychiatrist, and it is considered good practice that as an adult mental health professional he recognised a potential safeguarding issue concerning Josh, and began the process of involving the relevant agency. As will shortly be discussed however, there were failings in the processing system within Children's Social Care which resulted in the referral being misplaced and no action taken. **Recommendation 1**

5.1.10 It is believed that CT1 psychiatrist telephoned and emailed his referral to Children's Social Care on Friday 16th November 2012, although it is not clear who he spoke to or what time of day the referral was made. At 0839 hours on Monday 19 November 2012, the referral, in the form of an email, was forwarded from the Initial Contact Centre in the Local Authority to the Children's Assessment Team. The referral states that CT1 psychiatrist *'wondered what the emotional atmosphere is like in the house, and how this might be affecting Josh.'*

5.1.11 On receipt of this referral, information was placed on the ICS contact record and it is evident that the information was 'cut and pasted' onto the contact record directly from the referral email. The contact record was reviewed on Tuesday 20th November 2012 by the screener on duty that day and it is a matter of concern that the referral was not screened on the day it was processed by the Initial Contact Centre as this resulted in a total of four days (which, it is recognised, included a weekend), when no action was taken or considered. Nevertheless, when the referral was screened this resulted in the following:

- The Duty Assessment Officer was asked to advise the referrer to complete a referral form, as more information was required concerning Claire's mental health, timescales of the incidents, diagnosis, interventions by the Community Mental Health Team

and whether there was a father or any other children involved in the case.

- The Team Manager noted that the child was being safeguarded as he was in the care of his Maternal Grandmother, but that consideration needed to be given to advising her to seek legal advice with a view to obtaining a Residence Order.

- The Duty Assessment Officer wrote to CT1 psychiatrist on 20th November 2012 requesting the further information indicated above, and explained that Croydon's Children's Services would not be taking any further action until the further information required was received.

5.1.12 Until that point, apart from an apparently sluggish journey through the system, the referral had been dealt with appropriately and it is accepted that Children's Social Care needed more information on which to base their decision making. CT1 psychiatrist re-sent the referral via an email including some additional information, and that was received by Children's Social Care on 27th November 2012 at 11.30am. There was a gap of a week between Children's Social Care requesting further information and the referral form being re-submitted by CT1 psychiatrist. The reason provided to this Review was that *'there was a delay while the request for further information was discussed in the community health team'*, but by now 14 days had elapsed since Claire had attended the SLaM Community Health Team seeking help, during which time no assessment had been made of any concerns for Josh. **Recommendation 2**

5.1.13 For reasons which have not been fully established by this Review, even when the correct referral form was received by Children's Social Care it was 'filed away' without any assessment being made of the additional information it contained. As no contact was made with CT1 psychiatrist to request further information, or to inform him of the outcome of his referral, it would appear that that the referral form was not even assessed by any member of the Duty Team, or indeed any qualified social worker. The referral appears to have been merely placed on the electronic database (ICS) and no further action was taken. The Children's Social Care Agency Reviewer spoke with the ICS Manager and his assumption was that the referral was seen by a person known as a Screener who thought no additional information was provided and so the referral not assessed by the Duty Team Manager.

5.1.14 Further information concerning the procedure for processing contacts and referrals was provided to this Review by the ICS Manager. He explained that all Children's Social Care contacts are recorded centrally by Croydon Call Centre staff. These are then

passed electronically to the Duty Team where they are looked at by screeners, who are not qualified social workers. The screener then passes the contact onto a manager if further guidance is needed or if closure/no further action (NFA) is the recommended outcome. Where contacts/referrals are received by post, these go via a scanning team who then send the information electronically to the screeners. Emails are received by screeners directly via a joint Duty Email Box. The ICS Manager explained that since Josh's death the system has changed to ensure that no referral can be closed with no further action without being assessed by the Duty Team Manager.

5.1.15 The lack of assessment of a referral has featured in a recent serious case review undertaken by Croydon LSCB. The current Review has been unable to establish why there was no follow up to CT1 psychiatrist's referral of 27th November 2012. All that is known is that it was filed on ICS, with no further action. It was, however, the responsibility of Children's Social Care to inform the referrer of the decision to take no further action, and this did not happen.

5.1.16 It was evident that when CT1 psychiatrist's original verbal/email referral was made, the Duty Team Manager reviewing that referral considered there was a need for further information and was aware of the potential need for the Maternal Grandmother to obtain legal advice. A lesson learnt and accepted by Children's Social Care is that there is an urgent need for a system to be in place whereby it is not possible to file a referral on ICS without it being seen, assessed and signed off by the Duty Team Manager.

5.1.17 It is correct to say that although the referral was not put in terms which suggested an immediate safeguarding or child protection concern, CT1 psychiatrist clearly stated that there were ongoing child in need concerns due to Claire becoming extremely anxious and that she was the primary carer of a 2 year old child. He pointed out that she had threatened to take her life by putting a knife to her throat and that he was concerned about the possibility of future self-harm. CT1 psychiatrist made a clear request, *"I am hoping that this CAF referral will objectively assess the Mother and Grandmother's ability to meet the child's needs, and to suggest support to make up any shortfall'.*

5.1.18 It is the view of those conducting this Review that the failure to properly manage this referral within Children's Social Care was a missed opportunity for Josh. Once the extra information had been provided by CT1 psychiatrist in the correct manner the referral should have triggered an Initial Assessment by Children's Social Care. The GP Agency Reviewer commented that there was no contact made with the GP by Children's Social Care and that had this happened, there would have been an opportunity to share relevant information which may have influenced the decision making in this case. The

instigation of an Initial Assessment would have created an opportunity for formal sharing of information between agencies, including the GP.

5.1.19 Furthermore, Children's Social Care should have contacted CT1 psychiatrist, acknowledging receipt of the referral and explaining what action they were planning to take. Neither of these things took place, but it is also regrettable that having heard nothing as to the outcome of his referral, CT1 psychiatrist did not re-contact Children's Social Care to seek an update because had he done so it is likely the error in the referral not being properly assessed may have been discovered. CT1 Psychiatrist maintains that as far as he was concerned he knew that Children's Social Care had received his referral and *'did not suspect the referral was not being actioned'* by that agency, however the SLaM Trust policy and advice is clear that if no acknowledgment is received from the agency receiving the referral it is the responsibility of staff to follow up referrals to clarify what is being done, rather than make assumptions about the outcome. Having said that, it is once again highlighted that those conducting this review consider it good practice for CT1 psychiatrist to have made the referral in the first place and the primary reason for a failure to action it was due to a procedural failure within Children's Social Care. **Recommendation 2**

5.1.20 It is however important for this Overview Report to clearly acknowledge that none of the professionals working with Claire (including Psychiatrists in both the private and public sector, and her GP) considered her to be a direct risk to Josh. It is also important to note that in her written contribution to this Review, Josh's Grandmother also commented that she *'had no inkling of any danger to Josh because Claire was always a loving mum and at no time did she appear any sort of threat to her son, if anything, she always said she lived for Josh'*. It is now known that in the weeks leading up to Josh's death a private trained therapist was regularly meeting Claire at home, and her observations as well as conversations with the family, led her to believe that Josh was not at risk and that Claire had no active suicidal ideation. It is acknowledged that during early meetings with the therapist, Claire *'expressed some suicidal ideation…but denied any current or active intent or immediate plan'.* At their last appointment on 9th March 2013 the therapist reported that Claire *'denied any active suicidal ideation'* and *expressed some optimism for the future'.* The therapist noted ' *Throughout the course of therapy, no adult or child safeguarding issues were observed, elicited or reported.'* [1]

[1] "The family do not agree with the suggestion that Claire was optimistic and that there were no thoughts of suicide ideation".

5.1.21 Therefore even if an Initial Assessment had been completed, and information shared by all relevant professionals, it is highly unlikely that the outcome would have triggered child protection enquiries or steps being taken to remove Josh from the care of his Mother. However, it is reasonable to suggest that if Children's Social Care had carried out an Initial Assessment, a support package for Mother and Grandmother may have been an appropriate outcome. It is certainly the view of Josh's Grandmother that Children's Social Care should have visited the home and seen the interaction between mother and child, and that they should have been more *'proactive'*.

5.1.22 When looking for potential systems failures within this Key Episode, the following has been highlighted to this Review by practitioners at the SILP Learning Event.

- The difficulties with getting through to Croydon Children's Social Care 'frontdoor' (referrals desk) were highlighted by various professionals, including trying to speak with someone about referrals and checking progress. It was noted that extra staff are needed in CSC as there is a general sense of a difficulty for professionals to get through to the front line service in CSC in Croydon (accessibility). The need to have one point to call up to and feedback to was highlighted. It is noted that a Multi-agency Safeguarding Hub (MASH) has recently been set up in Croydon which, it is hoped, will improve information sharing and pathways.

- It was noted that the screeners of referrals are not qualified social workers. In a previous SCR a referral was scanned and placed on ICS without any further action being taken. It was only after the police officer in that case who made the referral followed up with CSC and action was then taken. Those attending the SILP Learning Event felt that there is a need for a qualified social worker to screen referrals.

- During the relevant period of this review it was possible for a referral into Children's Social Care to be filed away without ever being seen or checked by a social work manager. (NOTE: The ICS Manager confirmed that the system has now been changed to ensure that no referral can be closed/NFA, without being assessed by the Duty Team Manager).

- Adult Mental Health Professionals within Croydon may be unaware of the correct referral system when they feel a child may be at risk, or the fact that there is a requirement for Children's Social Care to acknowledge receipt of the referral and explain what action will be taken. Had this gap in knowledge not existed, the delay in Children's Social Care receiving a correctly formatted referral would have been

reduced by about a week and CT1 psychiatrist may have realised something had gone wrong, perhaps prompting a follow up call.

5.1.23 It was highlighted at the SILP Learning Event that there is a culture of overreliance on Children's Social Care for actions regarding a child, and it is not acceptable for other professionals to adopt a 'fire and forget' stance in respect of their referrals.

5.1.24 It has been reported by the SLaM Agency Reviewer that CT1 psychiatrist made a second referral to Children's Social Care on 17th January 2013, by resending the November referral form to Children's Social Care on 18th January 2013. Details of how this referral was made are not explicit within the SLaM notes and the current review has not been able to satisfactorily establish exactly why, or to whom, this second referral was made. It is therefore not known exactly what triggered this referral but it could be speculated that it was because Claire failed to attend a pre arranged appointment with CT1 psychiatrist the day before.

5.1.25 It is of great concern that no-one seems to have any proper record of this referral or the outcome. The psychiatrist (CT1) could not recall what referral form was completed or how the referral to Children's Social Care was made and SLaM records hold no correspondence letter attached to the system, which links to the referral screen. For their part, Children's Social Care has no record whatsoever of this apparent referral having been received, and consequently no action was taken by them.

5.1.26 The SLaM Agency Reviewer notes that there is limited evidence to account for decision making processes in relation to this second referral regarding Josh to Children's Social Care. The referral was believed to be simply a repeat of the November referral but there is no documentation which accounts for why a new referral was made and what new information or concern this was based on. No follow up is recorded in the SLaM notes and since the previous (November) referral had also not been followed up with Children's Social Care there is no evidence that Community Mental Health Team were aware of the outcome of either of their referrals. As discussed above, it is unacceptable that referrals are made in this way and then simply left with the referring agency, with no attempt to follow up or challenge an apparent lack of acknowledgement or action. **Recommendation 3**

5.1.27 It is acknowledged that this was the CT1 psychiatrist's first community mental health post and his supervision by senior colleagues was not sufficiently robust to highlight deficiencies in his note keeping which were identified by the SLaM Agency Reviewer. It

was however noted in the SLaM Report that following this incident, CT1 psychiatrist *'was able to rectify this deficit in record keeping'.*

5.1.28 Because of a complete lack of information about it, there is little that this Review can offer in terms of learning regarding this second referral. It is noteworthy however, that had it been correctly dealt with, any assessment of Claire's parenting capacity could have taken into account the recent events when she was admitted to hospital in Rotherham having taken an overdose, and admitted to Croydon University Hospital due to her feeling suicidal.

5.1.29 When analysing why there was a failure to properly record or follow up the two referrals it is important to acknowledge the following contextual information provided by the SLaM Agency Report, *'Caseload size and the ability to manage competing demands were highlighted as a contributing factor by staff interviewed within the Community Mental Health Team. This was compounded by covering duty at least I day per week, which could increase dependant on staff leave or sickness. The expectation of the service was that "walk ins" would also be assessed which added an extra pressure to this role. It was also noted at interview that approximately 500 clients were managed in outpatient clinics. Management of the team was also disrupted at the time of the incident as the team leader was removed from duties resulting in the Head of Pathways taking on management responsibility. Whist core management tasks were undertaken by the Head of Pathways the investigating team noted that management of the Community Mental Health Team was only an element of the portfolio of duties and demands.'*

5.2 The admission to Rotherham District General Hospital

5.2.1 In December 2012, Claire travelled to Rotherham to stay with a friend. Josh remained at home and was in the care of his Grandmother.

5.2.2 On the morning of 14th December 2012, Claire's friend was unable to rouse her and she called an ambulance. Claire was taken to Rotherham District General Hospital having taken an overdose of her prescribed medication. At the time of admission she was unconscious and staff were unable to verify her identity. After life support measures and neurological monitoring, Claire was moved to the Intensive Care Unit. It was noted on transfer that staff had information that she suffered from anxiety and depression.

5.2.3 As well as the ambulance crew attending the house where Claire became ill, there were also two police officers from South Yorkshire Police. These were uniformed patrol officers who did not have a specialist child protection role. The policy of South Yorkshire

Police regarding the management of children at risk is similar to other forces within the UK. South Yorkshire has a bespoke child referral form called GEN 117. This form should be completed when officers attend any incident and there is any concern or need for further investigation in relation to children. PC 1, one of the attending officers confirms that he was aware that Claire had a small child however he established that the child was in the care of Claire's parents and as a result of this information did not feel a need to complete the form GEN 117.

5.2.4 The Police Agency Reviewer offers no criticism in his report of these officers and points out, *'the officers were aware that Claire was to attend Rotherham General and be provided with psychiatric support from the relevant agency in South Yorkshire. It is also right to consider what additional support Claire or Josh would have been provided with if the form had been completed. It is anticipated that if the form had been generated no further action would have been required as Claire had already been referred to psychiatric support*.'

5.2.5 At the SILP Learning Event, The Police Agency Reviewer did express the view that the officer should have contacted Rotherham Children's Social Care who then would hopefully have contacted Croydon Children's Social Care. Had this happened, it is possible that the earlier referral from CT1 psychiatrist would have been accessed in their filing system, revisited and actioned properly.

5.2.6 Records within A&E and the Intensive Care Unit, fully document the care and clinical interventions at Rotherham Hospital. It is recorded that Claire's mother was contacted and stated she would visit from Croydon in the morning. It was established that the Grandmother was looking after Josh, reportedly in a safe environment. The Intensive Care Department at Rotherham Hospital does not deal with children, therefore, staff do not deal with safeguarding issues very often. In this case the hospital Safeguarding Team were not contacted to offer appropriate guidance on whether further enquiries should be made concerning Josh. Whilst care plans were robust in terms of intensive care and life support, staff at Rotherham did not 'think family' and liaison to agencies in Croydon in terms of Josh's welfare was not carried out. Given the gravity of the suicide attempt this would have been good practice. In particular, there is no evidence that Children's Social Care in Croydon were contacted in terms of Josh's welfare and it would have been good practice to alert the Hospital Safeguarding Team or the Liaison Specialist Paediatric Nurse so that information could be disseminated to services in Croydon to assist in planning.

5.2.7 Certain assumptions were made by staff at Rotherham Hospital. For example, it was established that Claire's parents were reported to be caring for Josh yet little was known about them or whether Claire

alone had parental responsibility, and the legal status of the child was unknown. It is fully accepted that Claire's poor condition on admission could mean that the full family circumstances would have been difficult to establish in the early stages but as time went on more could have been done to contact agencies in her home area.

5.2.8 This assumption that Josh's family, and his Grandmother in particular, could be relied upon as a 'protective factor' was made on several occasions by different professionals, often without knowing anything about her. Although all information suggests that she was a 'protective factor', in cases involving other children this may be a dangerous assumption and professionals need to refrain from making such assumptions but rather carry out a proper assessment to ensure that those being relied on to care for a child are, in fact willing and capable of doing so. **Recommendation 4**

5.2.9 Had contact been made with other agencies in Croydon it may have been confirmed whether or not the family were in fact appropriate people to care for Josh. In general, Josh is not mentioned in any great detail in the care plans and there are no details of his name and date of birth in the hospital records. Whether Claire had a partner or not is also not documented in hospital notes. It is the view of the Rotherham NHS Agency Reviewer that there were lost opportunities for hospital staff to gain information from the Croydon area with which to contribute to holistic plans of care. Although A&E and Intensive Care Unit staff access Group 2 Safeguarding Training, the voice of Josh in this case was not heard in terms of short and long term planning.

5.2.10 This admission of Claire to Rotherham Hospital highlights the barriers of adult focussed workers, particularly in a high dependency area, considering the welfare of the patient's child. In this particular case, communication was further complicated by the family originating in another area and no background information being easily sought. However, there were professionals at the hospital who could have been of assistance with this, including the Safeguarding Team and the Paediatric Liaison Specialist Nurse and these services should have been called upon. A view was expressed by the Rotherham representative at the SILP Learning event that it would also have been good practice for the Rotherham Hospital Trust and/or Mental Health Crisis Team also to have made a direct referral to Croydon Children's Social Care.

5.2.11 The day after her admission to Rotherham Hospital, Claire was referred to the Rotherham, Doncaster & South Humber (RDaSH) Crisis Team and a member of that team visited her for an initial interview on the evening of 15th December 2012. This assessment highlighted that Claire's current mental state rendered her unable to provide adequate care for Josh. The Crisis Team worker met Josh's

Grandmother and her Partner and was given assurance that they were taking responsibility for his care needs.

5.2.12 The plan of care for Claire was that she would be discharged from Rotherham Hospital the next morning (16th December 2012) to the care of her Mother and would return to her home in Croydon. This duly happened. The RDaSH Crisis Team worker spoke to someone in the Croydon Mental Health Crisis Team, who advised him of appropriate contact details of the relevant professionals in that area and a referral, dated 16/12/2012, was sent to the team and also a referral letter to Claire's GP. The referral contained details of the assessment carried out the previous evening and made reference to the information provided regarding Claire's inability to care for her child and also detailed that all care for the child was being provided by the maternal Grandmother.

5.2.13 It is very concerning that neither the SLaM Community Health Team, or SLaM have any formal record of receiving this referral from the RDaSH Crisis Team. The Crisis Worker at Rotherham does indeed seem to have liaised with Croydon Mental Health Services as it is documented on the discharge letter that a visit from the Crisis Team in Croydon will take place the day following discharge. At the SILP Learning Event, CT1 psychiatrist did recall seeing a referral letter from Rotherham to SLaM but this Review has been unable to discover why the referral was not properly recorded by Croydon mental health services and acted upon. **Recommendation 5**

5.2.14 Fortunately, Claire's GP was also copied in to the referral from the RDaSH Crisis Team in Rotherham and on the 17th December 2012 she made telephone contact with the duty worker at the SLaM Community Health Team requesting assessment for suitability for home treatment following Claire's overdose in Rotherham. A duty appointment was subsequently arranged for later the same day which Claire attended with her Mother. Claire reported acute overwhelming anxiety, panic attacks and insomnia, feeling useless, helpless and depending on her Mother.

5.2.15 It is noteworthy that during her discussion with the Independent Reviewers, Josh's Grandmother recalled that the family was promised three visits a day from a psychiatric nurse and that the RDaSH Crisis Team had been promised this service by Croydon. The SLaM Agency Report comments that at the appointment on 17th December 2012, the role of the Home Treatment Team was explored with the family but a referral to this service was declined. It now appears that the reason the service was declined is that there was a significant failure in terms of communicating to the family what the Home Treatment Team could actually offer.

5.2.16 In her written contribution to this review, Josh's Grandmother suggests that she and Claire were given misleading information by a SLaM clinical professional regarding the availability of home care and treatment. Specifically, it is claimed that the duty mental health nurse informed the family that SLaM did not support any type of home treatment other than the supervision of taking of medication, but because Claire felt she didn't need any external supervision as regards her medication intake, the service was declined. The information given to Claire and her mother was inadequate, and in fact there is a wide range of possible interventions available from the Home Treatment Team.

5.2.17 When discussing SLaM in her written contribution (see Appendix B), Josh's Grandmother used very strong terminology to describe her experience with staff at SLaM and how, in her words, they *"...denied my daughter home care, the very treatment that may have been a benefit to her'*. This is clearly a very important and emotive issue for Josh's family and it should be considered a point of learning that whether or not SLaM professionals thought they were giving clear advice, the family feel they were misinformed and left in a confused state about what home treatment was available.

5.2.18 As mentioned in paragraph 2.3.7 above, as well as the SLaM Agency Report, the SCR was also provided with a document entitled Acute Comprehensive Mental Health Level 2 Report, which was the product of an internal investigation by SLaM. When dealing with the episode relating to the provision of home treatment for Josh's mother, the SLaM investigators agreed that the family members were not given a clear explanation of what was available. In fact they were of the view that the registered mental health nurse who explained to the family what home treatment was available should have been clearer both in her description of the home treatment team and what interventions they could offer. The internal investigation report lists 23 potential 'interventions' that can be provided as part of home treatment but concludes, *'the full spectrum of home treatment interventions were not discussed with* [the family] *to allow them to make an informed decision about a referral to the team.'* The internal investigation also concluded that there was *'poor awareness of the principles of sharing information with service users*'.

5.2.19 The list of 23 potential interventions includes some activity which might arguably have been very relevant to Josh's safeguarding needs. For example the Home Treatment Team offers:

- Care planning, including working with the service user's family and carers
- Assistance with arranging childcare
- Child risk assessment
- Ongoing education and support to family members and carers

- Interventions aimed at maintaining and improving social networks

5.2.20 It is important for the SCR to seek to establish why the information provided to Claire on 17th December 2012 was so incomplete. The workload and management situation within the team during December 2012 was highly unsatisfactory as outlined in paragraph 5.1.29 of this report. The SLaM internal investigation report also refers to considerable pressures within the SLaM Community Health Team caused by that team having the *'highest activity'* within the Trust. It is also reported that during December 2012 there was a specific performance related problem with the Team Manager who in fact was suspended the following month. This might have contributed to a general lack of supervision for team staff, such as the duty Registered Mental Health Nurse who interacted with Josh's mother on 17th December 2012, as well as perhaps a general malaise in terms of properly recording referrals in and out. Having said that, the problems being experienced by the team cannot explain the lack of clear information being given to Claire and it is unacceptable that the family were apparently misled about what exactly the Home Treatment Team could potentially have done to help Claire and Josh.

5.2.21 A lesson learnt and accepted by South London and Maudsley NHS Trust is that as well as a verbal explanation, there should have been be a leaflet available to their duty mental health professionals which could be given to service users to help outline and explain all services available to them. This idea is included as a recommendation contained within the SLaM Acute Comprehensive Mental Health Level 2 Report. Since some of the services available relate to the safeguarding of children within families, LSCB should audit the introduction of this leaflet. **Recommendation 6**

5.2.22 In respect of the services provided in Rotherham, the RDaSH Agency Reviewer highlighted examples of good practice by the RDaSH Crisis Team clinician. The good practice cited includes, for example, that the assessment was thorough, that it gave proper attention to the parenting responsibilities for Josh, to Claire's own health needs and the arrangements in place to care for the child whilst her mental health was poor. The RDaSH Crisis Team worker also ensured that the Grandmother had information regarding how to access further help should her daughter's mental health deteriorate.

5.2.23 Whilst it is clear that the RDaSH Crisis Team clinician did make the correct referral to the SLaM Community Health Team, it is regrettable that somehow this referral was not properly recorded on the SLaM Community Health Team system, or acted upon, until the GP independently made contact the following day. There was undoubtedly a system/recording failure which, had it not been for the

independent referral from the GP, may have meant that Claire was not seen by anyone on her return from Rotherham after the serious attempt to end her life.

5.3 The prescription of medication

5.3.1 During her conversation with members of the Review Team, Josh's Grandmother said that she felt that Claire's excessive medication was partly to blame for her poor mental health, and she was particularly critical that doctors kept 'upping the dose' when a particular medicine was not having the desired effect. Claire's natural father was also asked to contribute to the Review and an interview was conducted by the Independent Panel Chair over the telephone. His main concern was expressed as, *'The services ain't no good. It's the doctors and the psychiatrists who gave her the stronger and stronger tablets so she took her own life.'* In as much as Claire's general anxiety affected her parenting capacity for Josh it is important for this Review to explore the concerns expressed by her Mother and natural Father.

5.3.2 It is clear that the various medical professionals treating Claire tried several different medicines in an effort to treat her. Claire tried and abandoned medication quickly, the pattern of use of medications is important to note here. Claire did not take any medication consistently and for a long enough period for them to be properly effective and for any side effects to settle down. The family GP confirmed that Claire was first prescribed anti-depressants in June 2012. The GP went on to describe the medication that Claire was prescribed. It was noted at the Learning Event that the GP tried to be very effective with the prescription of various medication, and sought appropriate advice as to which medication to try next and at which dose. The list provided by The GP is as follows, together with the effect.

1. Citalopram - problem of spontaneous bleeding on this medication. This medication is a first line drug which is usually prescribed by GPs.

2. Sertraline – problem of bruising on this medication. This medication is more of a calming type.

3. Citalopram – Claire was prescribed this drug after her A&E attendance (this was prescribed by a colleague of the GP). Claire was on this for a long time.

4. Venlafaxine – uncertain if the patient took enough doses to determine if this was effective or not.

5. Mirtazapine – due to not sleeping, but Claire did not react well to this.

6. Pregabalin – trialed this, but Claire experienced hallucinations and reported that her anxiety increased. The overdose in December was included Pregabalin.

7. On 17th December 2012, Claire was prescribed Promethazine and Citalopram 20mg was to continue.

8. Claire was also prescribed Propranolol (to take 3 times a day)

5.3.3 At the SILP Learning Event, The GP was told that her Mother felt Claire was wrongly prescribed increased doses of medication but the GP noted that dosages in the medication prescribed were not increased beyond the starting dose and that Claire was not on the medications long enough for this to occur.

5.3.4 The GP confirmed treatment doses do vary between person to person and it is not considered unusual to have to change medication as it is about finding the right drug for each person. The GP explained that if in doubt, she was able to telephone the medication review service for advice on medication. There is evidence that sometimes dosages were increased, for example on 4th December 2012, when Claire was seen by CT1 psychiatrist, he was concerned that she was being prescribed a sub-therapeutic dose of Pregabalin by the GP. CT1 psychiatrist called the GP to discuss increasing the dose of Pregabalin. Trying to find out 'what works' for a particular patient can involve raising or lowering medication levels, so there is nothing particularly unusual about suggesting an increased dose of a particular medication even though this may have seemed alarming to Claire's family.

5.3.5 At the SILP Learning Event, a Private Psychiatrist described Claire as not open to persuasion to medication and as having had negative experiences of medication, adding that it is difficult sometimes to separate whether it is anxiety or a side effect of the drug. He also explained that people have varying tolerance to medication and may be sensitive to certain drugs. He did not feel that there was any evidence of medical professionals wrongly 'upping the dose' in the way perceived by Josh's Grandmother.

5.3.6 During her conversation with the Independent Reviewers, Josh's Grandmother said that the care the family had received from the GP had been '*fantastic*'. It is noted in the GP Agency Report that The GP had many discussions with Josh's Grandmother who was extremely concerned about her daughter. She would contact the GP to provide an update of the home situation and progress, while the GP would talk with her about medication management at home. It is not recorded that any concern was raised during these meetings about increases in the medication prescribed.

5.3.7 Finally, the GP Agency Reviewer has made no adverse comment about the medication used to treat Claire, either in respect of the type or the amount.

5.3.8 Despite the perception of both her parents, based upon all the evidence presented to this Review there is no reason to conclude that the medication prescribed to Claire was incorrect in either type or quantity.

5.4 Sessions with private consultant clinical psychologist

5.4.1 On 18 September 2012, Claire attended a consultation with a Consultant Private Psychiatrist after a referral by her GP due to a bad experience with her anti-depressants. The services provided to Claire were an initial psychiatric consultation with advice on medication and therapy, and a referral to a Private Consultant Psychologist who saw her for five sessions of psychological therapy.

5.4.2 The ending of therapy was rather fragmented, with the rescheduling of appointments and Claire not attending as she was unwell. The family made contact with the service at the end of November 2012 to advise that Claire did not wish to continue and her last actual session with this service was on the 2nd November 2012.

5.4.3 At the SILP Learning Event the Private Psychiatrist explained that consultation included taking a full background history from Claire. Positive comments were provided showing the love for Josh, him being the most important person in her life and a commitment to look after him. The overall focus with the session was to address the Mother's needs but the Private Psychiatrist did not feel that anything said in the sessions with either himself or the psychologist should have triggered a referral about concerns for Josh. The presence of the Grandmother as a family support indicated that Josh was safe and raised no alarm bells. The Private Psychiatrist was asked what he would do if he did have a concern regarding a child, and he advised that the route he would take would be to raise any concerns through discussion with the GP.

5.4.4 A letter was sent to Claire's GP acknowledging the premature ending of therapy. As there were no concerns for Josh or anything that stood out regarding her parenting, this was not raised in the correspondence to the GP.

5.4.5 The overall focus of the sessions was to assess Claire and her son was seen as a motivating factor. It was noted during her sessions with the Psychologist that she appeared to have some separation anxiety in relation to her son. Claire indicated that she continued to sleep with Josh and felt scared when she was away from him or her Mother and wanted to be with them all the time. In her therapy

sessions she talked about how important her son was to her indicating that Josh was the only thing that she was really motivated and committed to.

5.4.6 There is no evidence that at this point Claire had attempted or discussed suicide, the first such occasion occurring some 11 days after her final therapy session. Whereas an attachment to Josh may well be seen as a positive factor, it could also be argued that such a dependence on him, combined with thoughts of suicide, may be considered a risk factor for the child.

5.4.7 It is noted that a 'full outcome statement' was shared with Claire's GP and the report from Private Psychiatry for the current Review indicates that there was *'good communication between the psychologist and both consultant psychiatrist and GP at the end of therapy'*. It is not however known whether the specific comments outlined in Para 5.4.5 above were shared. Had they been, this should have triggered a closer analysis of the safety of Josh when the GP later became aware of Claire's suicidal thoughts and serious attempt at suicide over the next few weeks. It might be reasonable to suggest that a potentially active suicidal patient with an apparently extraordinary reliance on her child as the reason to live and be motivated should cause professionals to consider the safety of that child. However, at the SILP Recall Event, CT1 psychiatrist offered the view that he would not have interpreted this reliance on Josh as making it more likely that he was at risk from his mother, but rather that he would have seen Josh as a protective factor in keeping her alive.

6. Conclusions and Summary of what has been learnt

6.01 The death of Josh could not reasonably have been predicted by any agency or individual who knew them or had any information about them. This Serious Case Review concludes that no professional, nor any family member, had any child protection concerns for Josh during the period covered by the Review. A psychiatrist (CT1) from a SLaM Community Mental Health Team did have concerns about how the atmosphere in the family home might be affecting Josh but did not himself have any real concerns for his physical safety.

6.02 Although some procedural and individual failings were identified by the current Review, there is no evidence to reasonably suggest that any agency providing Josh or his family with a service failed *in any way which had a bearing on the outcome for him*, to fulfill their responsibilities, statutory or otherwise, to safeguard and promote his welfare.

6.03 There is evidence that a failure in the processing arrangements within Children's Social Care in respect of a referral from a Psychiatrist, led to a missed opportunity for Josh's needs to be properly considered by an Initial Assessment, and potentially for the family to be offered support with parenting for Josh. It is however unlikely that the standard discussions between partner agencies and the family which would have been triggered by such an assessment, would have revealed any concerns of a child protection or safeguarding nature.

6.04 It is an example of good practice that the Psychiatrist treating Claire recognised the possible effect her condition may have on Josh and that he made a referral to Children's Social Care in order to better assess his wellbeing and needs.

6.05 Mystery surrounds an apparent second referral to Children's Social Care from the same Psychiatrist. It is reported by the Psychiatrist that the referral was made on 18th January 2012 after a missed appointment by Claire. There is no record of the referral in the Children's Social Care or SLaM systems and it appears to have been completely 'lost'. Needless to say, no action was taken.

6.06 The referral system in Children's Social Care has been tightened up and a monitoring system which is routinely operated is now in place and no referral can be classified as 'No Further Action' without being assessed by the Duty Team Manager. In addition, a Multi Agency Safeguarding Hub (MASH) has been operational within the local authority area since October 2013. A health representative will sit in the MASH and as a result a referral from a health professional to Children's Social Care should result in a more streamlined process.

6.07 The family GP's input into Claire's life, as well as the life of the family as a whole, was hugely beneficial and the GP received a great deal of praise from the family for her support and health care. The GP agency review however, has identified that the consideration of Josh's needs was lacking. A view was expressed at the first SILP Learning Event that the GP did not consider that other agencies needed to know the information that the GP held about Claire, and the potential impact on her parenting capacity. In particular, this was not shared with the Health Visiting Service and this was a missed opportunity to potentially discuss with Claire the possibility of providing her with additional parenting support.

6.08 There were examples of good practice by the staff at Rotherham General Hospital and Rotherham, Doncaster & South Humber Crisis Team. The good practice included prompt emergency care, a prompt assessment of Claire's needs and a good follow up with professionals in her home area. However, there is evidence that Rotherham Hospital did not sufficiently 'Think Family' in their assessment, and

although they made good follow up with SLaM in terms of the mother, they did not follow up with Croydon Community Health Services in terms of the child and the mothers parenting capacity.

6.09 A referral from the Crisis Team at Rotherham to mental health professionals in Croydon was not properly recorded and no record of it could be found in SLaM systems. It is clear that a referral was made so together with the failure to locate any information about the January referral to Children's Social Care it can be concluded that the system of recording referrals both into and out of the SLaM Community Mental Health Team was dysfunctional and needs to be tightened up.

6.10 There was no evidence of any error by medical professionals in respect of prescription of medications to Claire, but it is likely that she failed to stick with some medications for long enough for them to have the anticipated effect on her wellbeing. Since those family members caring for her perceived that an excess of medication was detrimentally affecting Claire, there was a need for those prescribing medication to better explain to Claire and her Mother that if the medicine was not used for the recommended period of time it may have no effect, or it may actually appear to be making the patient feel worse.

6.11 Family members were confused by some apparently inconsistent and misleading advice given by SLaM mental health staff about the availability of medical care and other support within the home for Claire and her family. Specifically, a duty Registered Mental Health Nurse failed to explain to Claire and her family the full range of services offered by the Home Treatment Team. This confusion caused great anxiety to those caring for Claire and led the family to continue accessing private mental health providers because they had lost faith in NHS providers.

7. Recommendations for Croydon SCB

These recommendations should be read in conjunction with the Action Plan which provides detail about methods of implementation and timescales.

Recommendation 1

The LSCB Chair should request a report from Children's Social Care which fully explains the improvements made in the referral system within that agency, and the Board should audit the improved system to ensure that referrals are promptly assessed by a social work manager or practitioner rather than solely by a screener with no social work background or training.

Recommendation 2

The LSCB should ensure that the safeguarding training provided for adult mental health professionals includes the specific requirement to follow up any referrals made in the event that an acknowledgement of the proposed action is not received. The LSCB should request that each relevant employer disseminates a memorandum to this effect to all medical staff who have already received the full training available.

Recommendation 3

The LSCB should ensure that the safeguarding training provided for adult mental health professionals includes learning about the level and amount of information required by Children's Social Care, as well as the need for clarity about what action the referrer feels may be needed in a particular case.

Recommendation 4

Although there is clear evidence that his extended family provided the best possible care for Josh, without knowing anything about her, assumptions were made that the Maternal Grandmother was able and willing to take on the parenting responsibility and was a 'protective factor' in Josh's life. The LSCB, through its training, should stress the need for all professionals to challenge assumptions regarding the protective effect of family members in the absence of an in depth assessment or legal order relating to the situation.

Recommendation 5

The LSCB Chair should seek a letter of clarification from South London and Maudsley NHS Foundation Trust explaining how the recording system of incoming and outgoing referrals to and from SLaM has been improved to ensure that in future details of such referrals can be quickly located.

Recommendation 6

The LSCB should monitor the development and introduction by SLaM of their proposed leaflet designed to help clinical staff clearly explain to service users the various home treatment possibilities available.

8. Recommendations for individual agencies

The preparation of individual agency recommendations is not the responsibility of the Independent Overview Report Author but they are contained in the Individual Management Review Reports. The recommendations were drafted by the Author of each report and have been accepted as SMART by the senior officer signing off the Agency Report on behalf of each agency.

Bromley Healthcare

Recommendation 1

It would be beneficial for safeguarding children training to include more about attachment and parent-infant relationships.
Action: To highlight this to trainers within Bromley Healthcare for immediate inclusion.

British Transport Police

Recommendation 1

Officers from South Yorkshire and from the Metropolitan Police should have created referrals in relation to contact with a vulnerable child. PPU managers in BOTH Forces to be advised of the circumstances of the deaths and cascade learning across Force areas.

Croydon Health Services

Recommendation 1

For Community Midwives who visit women who have delivered at a hospital other than Croydon University Hospital to make a copy of the record of care they have delivered to the baby and mother before sending the records back to the hospital where antenatal care and delivery was provided. This will allow a robust trail of documentation to be held in archive of the intervention that took place between the Community Midwife employed by Croydon University Hospital and the baby and mother.

Recommendation 2

The use of prompts (to remind staff treating adults who may be parents or carers, to consider parenting capacity in relation to reason for attendance and identified vulnerability) to be embedded into practice within the adult emergency department.

Recommendation 3

CUS to review the Family Health Needs Assessment documentation in relation to recording evidence of mental health assessment.

Recommendation 4

To ensure that where two or more services are responsible for the overall needs of a parent or care, there is a robust communication between all parties to ensure that the risks that this parent or carer may pose to a child have been considered. There needs to be a greater understanding of the governance structures in place between Croydon Health Services NHS Trust and South London and Maudsley NHS Trust. This is particularly in relation to the Psychiatric Liaison Nurse Team based IN ED at Croydon University Hospital.

Recommendation 5

The CUS team needs to improve links with GP's to raise awareness of the need to share information in particular when an adult who is a parent or carer is receiving treatment and support for any health issue that may impact on their parenting capacity.

Children's Social Care

Recommendation 1

That Children's Social Care reviews the ICS to ensure that no referral can be filed without being reviewed and signed off by the Duty Manager. This should be undertaken by the ICS Manager (to be completed by September 2013) The outcome: to ensure that no

referral is missed, which requires follow up action , where there are child protection concerns.

Recommendation 2

That Children's Social Care considers undertaking an audit of referrals received by the Duty Team to ascertain that no referral has been missed where there are potential child protection concerns. To be commissioned by the Head of Safeguarding and Quality Assurance (to be completed by December 2013). The outcome: to offer reassurance that referrals are being appropriately assessed

Croydon CCG - Independent Contracted Services

Recommendation 1

It is vital to ensure that the lessons learnt from this review are disseminated to all GPs and relevant practice staff in order to provide the opportunity to learn from the findings of the review and develop their confidence and competence in managing such cases.

Recommendation 2

Consideration must be given as to how GPs are able to access advice, safeguarding supervision and case reflection in order to provide support and guidance at an early stage in their work with vulnerable families. A suitable model must be identified and embedded in practice with time made available for reflection, comprehension and discussion.

Recommendation 3

All GPs should have up-to-date information on the location and contact details of Health Visitor's to ensure appropriate and timely communication regarding clients with safeguarding concerns. Consideration must be given as to how relationships between community practitioners can be enhanced in order to improve relationships and multi-agency working.

Recommendation 4

The concept of 'Think family' and the need to consider the impact of historical issues on parenting capacity and current risk must be included in safeguarded children training. This will need to be completed in partnership with NHS England who have responsibility for the co-ordination and funding of safeguarding training for GPs.

Recommendation 5

There needs to be thoroughness in assessment, in order to assist practitioners in missing potential vulnerabilities and risk factors.

Recommendation 6

GPs should consider inviting Health Visitors to their practice meetings in order understand assess and analyse risk factors in vulnerable children and their parents carers

Recommendation 7

Staff involved in this review must be debriefed on its findings and supported through the process of learning.

London Ambulance Service

The Trust is of the view that the attending ambulance staff should have submitted a safeguarding referral to the local social services department following the 999 calls on 17 January and 22 March 2013.On 22 March 2013, a referral to local social services would have been the normal course of action following a sudden and unexpected child death. This was not done on this occasion as the crew on scene had no details about the child and mother (no address, names, DOB etc). However, we acknowledge that the reasons for not completing a referral should have been documented on the patient report form. Staff have been provided with safeguarding supervision by the local management team regarding the non completion of the referrals and the importance of documenting that safeguarding concerns have been considered in all cases involving children. The Head of Safeguarding Children is currently rewriting the SUDICA Guidance and this will be circulated to all staff before the end of July 2013.

Rotherham, Doncaster & South HumberNHS Foundation Trust

Recommendation 1

A Standard Operating Procedure (SOP) to be developed within the Crisis Team to direct staff in cases of out-of-area referrals to verify that the referral has been received.

Recommendation 2

An audit of the usage of the above Standard Operating Procedure (SOP) to be undertaken.

Rotherham NHS Foundation Trust

In recommending improvements in the area, there requires an increased awareness and understanding of how acute illness will

affect parental capacity, and to ensure a child in the family is safe during this period.

The Safeguarding Team at Rotherham Hospital will plan with the Departmental Manager to offer a group supervision session around the case. This session to give staff the opportunity to add to a pathway of what to do/approach if an adult is admitted with a condition which may affect parenting capacity. This pathway to be in line with Rotherham Safeguarding Procedures and The Rotherham NHS Foundation Trust Safeguarding Children Policy.

Care Plans in acute areas to include information regarding a child within the family and other significant family members. Also, if there are any other agencies working with the family who will be need to be contacted.

The Rotherham Foundation Trust has a Discharge Planning Protocol in place. This also includes adult areas where a situation may affect parenting capacity. This is due for renewal September 2013. The adult patient and parent will be renewed to add clarity to the process, including when the family originate in another area.

SLAM

Recommendation 1

It is recommended that a more robust administrative systems to be put in place within the Community Mental Health Team to enable the recording of case allocation and appointments not attended. This is due to evidence of sporadic poor recording of missed appointments and some key correspondence.

Recommendation 2

Staffing within the Community Mental Health Team also needs review due to the number of clients held within the outpatient clinic. What is of note is that although Claire had not been allocated a care co-ordinator she was seen and assessed when she presented at the team base. It is evident that the team included the family in the assessment but there were missed opportunities to fully and meaningfully assess the family as a protective factor.

Recommendation 3

Record keeping across the teams needs review as IAPT notes and information were not routinely recorded within the central electronic notes system which makes it difficult for teams within the Trust to have a clear picture of what each other is doing and how a service

users presentation to one team might impact on the assessment of another.

Recommendation 4

IAPT should review their process of closing cases when there is no response to a single opt-in letter as this may inadvertently disadvantage vulnerable service users and lead to missed opportunities to support and engage those in need of the service.

Recommendation 5

Analysis of risk to children should be comprehensive and explicit in order to fully account for risks but also to ensure there is accountability and clarity in decision making processes. There is clear evidence that the team junior doctor made a good assessment of the welfare of Josh. However a key opportunity was missed as the doctor did not follow up the outcome of the referral. There is also evidence of some confusion regarding the terminology of the referral.

Recommendation 6

Trust services need to improve the focus on Think Family within assessments and risk assessments. This is particularly relevant when assessing the protective function of families. These assessments need to be explicitly recorded and include a clear rationale of decisions. These assessments whilst including families, need to include individual assessments to inform practice. Within the Think Family agenda practitioners should also be mindful of partner agencies with whom information could be shared for example in this case the health visitor.

Recommendation 7

The Trust system of monitoring referrals to Children's Social Care needs to be reviewed within the Community Mental Health team to ensure it is consistently effective. A key opportunity was missed as the team junior doctor did not follow up the outcome of the referral and the referral monitoring system which each team is expected to have implemented and be monitoring should safeguard against this happening again. At the time of this incident, this referral monitoring system was in its early stages however the team should take action to reassure the Trust that this system has been implemented and is consistently monitored by the team

Recommendation 1

Safeguarding training at all Levels to continue to embed learning from SILP.

Recommendation 2

Assessment of Vulnerability Checklist in ED will highlight impact of parenting capacity and actions taken.

Recommendation 3

Improve information sharing with Croydon Children's Health Services.

Appendix A Terms of Reference

CROYDON SAFEGUARDING CHILDREN BOARD

SIGNIFICANT INCIDENT LEARNING PROCESS
SUBJECT : JOSH
BORN : 16.03.10

SCOPE

Only the subject child
Time period :
Early June 2012 (date of first presentation to GP with anxiety related issues)
To
22 March 2013 (date of incident)

Agencies are asked to provide relevant information relating Claire's pregnancy and antenatal period and to the 3 head injuries sustained by Josh even where these fall outside the scoping period.

FRAMEWORK

Serious Case Reviews and other case reviews should be conducted in a way in which :

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;

- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings

(Working Together para 10, March 2013)

AGENCY REPORTS TO BE COMMISSIONED

1. British Transport Police (incorporating analysis of response of metropolitan police)
2. Ambulance
3. SLAM Psychiatrist
4. Private psychiatrist
5. CBT Practitioner
6. Princess Royal Hospital
7. Croydon University Hospital
8. Rotherham Hospital
9. Childcare
10. Children's Social Care

TERMS OF REFERENCE

Generic Terms of Reference

None

Agency Specific Terms of Reference

4. What was known and identified by professionals about Claire's and Mr T's parenting capacities and possible risks to Josh?
5. Did assessment and care plans take account of the whole family and potential risks to Josh and how was information shared with relevant agencies?
6. What was the outcome of the referral to Children's Social Care and the rationale behind the decision making process?

Appendix B

Written Contribution from Maternal Grandmother (Anonymised and attachments not included due to personal information therein)

SERIOUS CASE REVIEW: MY DAUGHTER & MY GRANDSON

From May 2012 to September 2012 my Daughter started having panic attacks and became increasingly anxious, my Daughter was prescribed medication, the medication started to have a detrimental effect on her physical wellbeing, my Daughter on occasions had suicidal thoughts and at times looked in a trance like state palpipations etc. I took her to see a psychiatrist because by now I was extremely concerned about her wellbeing

On the 14th December whist visiting friends in Rotherham my Daughter made a serious attempt on her own life, she was taken to intensive care where she was cared for by a mental health professional see attachment (1).On our return we visited our GP on the 17th who made us an appointment at the Community Mental Health Team my GP believed we would be seeing a psychiatrist we were seen by a CPN nurse and explained that the mental health professional recommended home care for my Daughter this would have been highlighted on the letter he had faxed to Croydon, CPN nurse response was to tell us that home care was unavailable at the Community Mental Health Team. my Daughter was prescribed further medication which included Olanzipine. Following a visit to my Daughters GP she stopped my Daughter using this medication because she had not been advised that my Daughter had been prescribed it and why.

Prior to the 14th December and my Daughter's attempt on her life, my Daughter was on medication and was receiving CBT which I funded myself I took this course of action as it was explained to me the NHS list was long and that my Daughter required prompt treatment. By now I was becoming very concerned about My Daughter's state of mind and behaviour even going to the extent of holding a knife to her throat on occasions and we always had to be vigilant when my Daughter was at home to ensure she didn't leave the house without our knowledge because of the constant threats she made against herself.

At our first meeting with SLAM I raised the subject of lack of home care and was told by a Doctor who was present that home care was indeed available to my Daughter. You can imagine my shock on hearing this because I believed along with our GP this could have solved many of my Daughters problems as it was because of the CPN nurse's lack of knowledge my Daughter was denied this treatment. Whether or not this treatment would have been suitable is not the issue - the issue is why was this nurse so badly informed my experience is that my Daughter had absolutely no continuity of care and met no one she had confidence in other than the mental health professional There appeared to be no care plan for my Daughter and a complete lack of any professional management

I would like to note my Daughter had joined the waiting list at number 86 on our return from Rotherham and following intervention and a member of staff of SLAM my Daughter was told following a telephone call she was near to the top of the list. Some days later a letter arrived saying they had not heard from her she had been taken off the list, a further phone call reinstated her to number 49.

During our visit on the 17 December my Daughter was prescribed medication and to carry on waiting for CBT. I would like to make it clear that in no way did I believe private CBT would be superior to NHS CBT I was frantic to get treatment for my daughter as I did not want another attempt on her life. I would like to say there was never any care plan discussed with my Daughter and myself for the best way forward to treat My Daughter, I would describe the care my Daughter received in this place as sticking plaster treatment and I would like an answer to the question that when a person accepts private treatment are they regarded by the NHS as a patient who's treatment is finished.

The loss of my Daughter and my Grandson cannot be put into words and my belief is a result of a department lacking any proper management, lacking direction, disinterested and ill-informed staff whose lack of training denied my daughter home care the very treatment that may have been a benefit to her.

CBT

Firstly I was directed to a CBT register where I had the task of selecting a therapist, how was I supposed to make an informed choice when I had no knowledge of CBT. I have no knowledge of regulations or qualifications?

Having studied CBT registration documents relating to the NHS I can see it is a rigorous screening programme to decide on suitability there are also sections that relate to childcare & child safety I have requested my Daughter's records from my Daughters CBT therapist

to see if the same type of process was followed with the care she provided. If so is it possible there may have been some early warning signs to my Grandsons safety and my Daughters suitability for CBT. I enclose samples of various NHS forms that would give a therapist a lot of information when completed see paragraph below Please see attachment (3) private CBT registration form

From what little I have learnt from CBT on the NHS I do believe that the level of care and expertise is somewhat greater than when one has to seek private therapy see copied samples of registration forms Please see page 4 attachment (2) most important bold type **We are not a crisis service we are not able to meet the needs of people who are actively suicidal** (yet 24 hrs out of intensive care my Daughter was still being recommended for this type of treatment) my Daughter was originally offered ten sessions she did not take this up as she felt it was not enough to treat her condition she should have been informed at this point that she could self-refer and have more treatments this would have given my Daughter more confidence because she would have been aware that she could have had more sessions if the treatment was benefiting her. See attachment (4) following the call my Daughter received I had a conversation with someone at Purley but I was not made aware that if my Daughter felt she required more sessions at the end of the course she could self-refer. Enclosure if this is accurate about my Daughters state of mind would CBT have been suitable treatment I am asking this question for my own piece of mind whatever the answer may be.

Care for My Grandson

With regard to my Grandson I had no inkling of any danger to My Grandson because my Daughter was always a loving mum and at no time did she did she appear any sort of threat to her son if anything she always said she lived for my Grandson. When my Daughter was at her worst and couldn't cope we took over my Daughter was never left alone with my Grandson, my Grandsons life did not change when my Daughter wasn't well my Grandson always gave his mum a kiss in the morning before he went to his child-minder and before he went to bed at night, he saw his mum on a daily basis even though my Daughter was unwell

There was no contact with any children's services, I assume it was accepted that my Grandson was well cared for, but how did they know they never saw him at home with his mother, considering that my Daughter had a mental illness and took my Grandsons life should the service be more proactive better still his mum should have had her treatment she had a little boy to look after.

I would like the enquiry to look into how much information was shared among agency's regarding my Grandsons safety and wellbeing, were the child care agency's aware of my Daughters illness and an attempt on her life

Why so little involvement by childcare for a child with a suicidal mum Protection of children act requires agency's to share information amongst agency's what evidence is there of any communication between SLAM and the relevant childcare departments.

Why was there no contact from childcare to my Daughter and myself. If there is statutory requirement for health care and childcare agency's to communicate for protection of children, who decided in this case that intervention by child care was not needed.

Reference the LSCB Chair's letter 22.7.13 it is really not satisfactory as it doesn't answer the issues I raised in my email it took a further two weeks for him to reply after prompting, we fully understood the protocol of this meeting and excepted that the original letter gave no hint of the fact that I would be unable to bring someone of my choice hence a considerable amount of wasted time however LSCB Business Manager's behaviour given my circumstances was inexcusable. Further to this I am still waiting for a reply to the two emails I sent her regarding this matter, she did say this was the first case of this kind.

Correspondence

We are still searching for the letter following our visit on the 17 December from Community Mental Health Team, to the GP so far this letter has not come to light and we cannot locate it, this would have been a most important letter because it was the first visit to Community Mental Health Team since my Daughters attempt on her life on 14 December both myself and the doctor have doubts to such a letter was written otherwise why can it not be found

I would like to say our wonderful GP had treated both my Daughter and I through the most appalling times of our life has always been available and given us a huge amount of time during our numerous calls and visits. I would also like to mention all the other people working at the practice for their kindness. I would also like to commend the mental health professional for his professional approach and my belief in his diagnosis of my Daughters condition and how ill my Daughter really was, I would also like to draw attention to the lack of respect shown to my Daughter and myself by a member of staff that told my Daughter she was lucky to have a roof over her head, its more due to the fact that I work to pay my mortgage are staff not trained to keep this sort of comment to themselves.

With reference to the CBT Therapist I would like to say how professional and dedicated she was with my Daughter's treatment and to note how helpful and cooperative she has been.

Due to the understandably long wait for counseling for myself I found a charitable bereavement counseling service in Bromley there I see a member of staff who previously worked at Bethlem and has been an enormous help to me, she used two words to me, urgent and compassion. Which I have not heard from anyone else. I am making these comments so that future victims of suicide can receive prompt help that is proactive not reactive

Our lives are destroyed, I wish no one would ever have to lose a child, that's why I want to share with you what it is like for us as a family as a mother you give birth to your child look after them bring them up encourage them and then they become ill and are in the hands of someone else and you hope and pray they will help them get better in this case it didn't happen as a mother the disbelief that this really happened how could this happen? My Daughter would not harm anyone and not my Grandson. The awful yearning of wanting to pull them back and you know you can't, no more kisses no more hugs every day that constant loss, not being able to see her smile not hearing her laughter no girly chats not seeing my Daughter and Grandson having fun together.

My Daughter was always there for us and the spats a mum and daughter have, never to have proud moments a mum has while their children are growing up, never to be a grandmother herself one day I always thought we would grow old together, family get-togethers birthdays and Christmas will never be the same the total sadness and despair I live with every day and will be with us every day gone is our happiness

For a sister the companionship always being able to talk to each and having a row that's family life, the laughter they shared at family get-togethers my daughters are in bits thank goodness my Daughter's niece and nephew are young people although being very upset are able to get on with their lives a lot better than their mum and aunty no more holidays together my youngest daughter who's not able to have children not only as she lost a sister, she adored her nephew. Gone is their happiness.

Our Grandson, I will never him say nana hear his laughter and see that big mischievous grin. We used to dance to the radio or the TV whenever he heard music he would start dancing, he loved playing in the park he kissed trees and rolled down the hills he loved the garden going on his slide he wasn't so keen on his swing, playing with his Fireman Sam ball he loved picking the flowers only the heads after he

smelt them, he loved playing in his paddling pool no more bathtimes he loved his bubbles and soaking the floor, he loved bedtime stories and we always got a big kiss at bedtime. He loved to sit and watch his favourite TV programmes with you He used to help put a teabag in my cup when I came in from work he thought he was making my tea no more feeling shattered when he wanted you to play with him when you came in from work no days out. No sleepovers at aunty and having treats playing with the dogs, no visits to aunty to see the horses, no more fun with mummy going on holiday and visiting friends. Our happiness gone

For my Grandson, he will never go to school, have friends, have birthday parties never have an ice cream, no more holidays the list is endless we will never see him grow up to be a fine young man, his first girlfriend a career getting married and having a family of his own, whilst driving you have to pull over as you are overcome with tears you see an ice cream van with children waiting to buy their ice creams. My Grandson will never do that or pass a playground watching the children having fun, he will never do that its heartbreaking going shopping which you try not to do avoiding all the shops you visited you know you will never be able to buy him clothes or toys having to come out of a supermarket because you get upset seeing the children running around I could go on for us this is never ending

Work is our saviour you have to focus unfortunately it's not 24/7.
It is made even more painful by the neglect my Daughter encountered and will always be convinced that the deaths of my Daughter and my Grandson could and should have been PREVENTED.